12. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

See items 12.a. through 12.d.

12.a. Prescribed drugs.

The following providers are eligible for payment for dispensing prescribed drugs:

(1) A pharmacy that is licensed by the Minnesota Board of Pharmacy.
(2) An out of state pharmacy that complies with the licensing and certification requirements of the state in which it is located.
(3) A physician located in a local trade area where there is no Medicaid enrolled pharmacy. To be eligible for payment, the physician shall personally dispense the prescribed drug according to applicable Minnesota Statutes and shall adhere to the labeling requirements of the Minnesota Board of Pharmacy.
(4) A physician or nurse practitioner employed by or under contract with a community health board, for the purposes of communicable disease control.

The following limitations apply to pharmacy services:

(1) With the exception noted below, the prescribed drug must be a drug or compounded prescription that is made by a manufacturer that has a rebate with the Health Care Financing Administration (HCFA) and included in the Minnesota Department of Human Services drug formulary. The formulary is established in accordance with §1927 of the Social Security Act. See Drug Formulary.

A prescribed drug is covered if it has Investigational New Drug (IND) status with an IND number by the United States Food and Drug Administration (FDA), even though the manufacturer does not have a rebate with HCFA. When the prescribed drug receives FDA approval, the manufacturer must have a rebate agreement for the drug in order for the drug to be covered.

(2) A prescribed drug must be dispensed in the quantity specified on the prescription unless the pharmacy is using unit dose dispensing or the specified quantity is not available in the pharmacy when the prescription is dispensed. Only one dispensing fee is allowed for dispensing the quantity specified on the prescription.

12.a. Prescribed drugs. (continued)

(3) The dispensed quantity of a prescribed drug must not exceed a three-month supply.

(4) An initial or refill prescription for a maintenance drug shall be dispensed in not less than a 30-day supply unless the pharmacy is using unit dose dispensing. No additional dispensing fee shall be paid until that quantity is used by the recipient.

(5) Except as provided in item (6), coverage of the dispensing fee for a particular pharmacy or dispensing physician for a maintenance drug for a recipient is limited to one fee per 30-day supply.

(6) More than one dispensing fee per calendar month for a maintenance drug for a recipient is allowed if:

(a) the record kept by the pharmacist or dispensing physician documents that there is a significant chance of overdosage by the recipient if a larger quantity of drug is dispensed, and if the pharmacist or dispensing physician writes a statement of this reason on the prescription; or

(b) the drug is clozapine.

(7) A refill of a prescription must be authorized by the practitioner. Refilled prescriptions must be documented in the prescription file, initialed by the pharmacist who refills the prescription, and approved by the practitioner as consistent with accepted pharmacy practice under Minnesota Statutes.

(8) Generic drugs must be dispensed to recipients if:

(a) the generically equivalent drug is approved and is determined as therapeutically equivalent by the FDA;

12.a. Prescribed drugs. (continued)

(b) in the pharmacist's or dispensing physician's professional judgment, the generically equivalent drug is safely interchangeable with the prescribed drug;

(c) the charge for the substituted generically equivalent drug does not exceed the charge for the drug originally prescribed; and

(d) the practitioner has not written in his or her own handwriting "Dispense as Written-Brand Necessary" or "DAW-Brand Necessary" on the prescription.

(9) Over the counter medications must be dispensed in the manufacturer's unopened package, except that Sorbitol may be repackaged.

(10) The following limits apply to drugs dispensed under unit dose packaging:

(a) Dispensing fees for drugs dispensed in unit dose packaging shall not be paid more often than once per calendar month or when a minimum of 30 dosage units have been dispensed, whichever results in the lesser number of dispensing fees.

(b) Only one dispensing fee per calendar month will be paid for each maintenance drug, regardless of the type of unit dose system used or the number of times during the month the pharmacist dispenses the drug.

(c) An additional dispensing fee per prescription shall be paid to pharmacists using an in-pharmacy packaged unit dose system (except for over-the-counter [OTC] medications) approved by the Board of Pharmacy for the return of drugs when dispensing to recipients in a long-term care facility if:

(i) the pharmacy is registered with the Department by filing an addendum to the provider agreement;

12.a. Prescribed drugs. (continued)

(ii) a minimum 30-day supply of the drug is dispensed, although a lesser quantity may be dispensed for an acute course of medication therapy for a specified time period;

(iii) the national drug code from the drug stock container used to fill the unit dose package is identified to the Department;

(iv) the unit dose package containing the drug meets the packaging standards set forth in Minnesota Statutes that govern the return of unused drugs to the pharmacy for reuse and documentation that unit dose packaging meets permeability standards of the Board of Pharmacy; and

(v) the pharmacy provider credits the Department for the actual acquisition cost of all unused drugs that are eligible for return and reuse.

(11) Delivery charges for a drug are not covered.

Drug Formulary:

All drugs and compounded prescriptions made by a manufacturer that are covered under a signed rebate agreement with HCFA are included in the drug formulary, with the following three limitations on coverage:

(1) The following drugs require prior authorization:
- (a) Alglucerase (Ceredase)
- (b) Botulinum Toxin Type A (Botox)
- (c) Demeclocycline (Declomycin)
- (d) Epoetin Alfa/Erythropoietion/EPO (Epogen and Procrit)
- (e) Filgrastim/G-CSF (Neupogen)
- (f) Granisetron (Kytril): for > 4 consecutive weeks continuous treatment
- (g) Interferon Alfa-n3 (Alferon N)
- (h) Interferon Gamma-1b (Actimmune)

12.a. Prescribed drugs. (continued)

(i) Lansoprazole (Prevacid): for > ~~8~~ 4 consecutive weeks continuous treatment
(j) Omeprazole (Prilosec): for > ~~8~~ 4 consecutive weeks continuous treatment
(k) Ondansetron (Zofran): for > 4 consecutive weeks continuous treatment
(l) Sargramostim/GM-CSF (Leukine and Prokine)
(m) Viagra (Sildenafil)

(2) The following categories of drugs subject to restriction under §1927(d)(2) are not covered:

(a) Agents when used for anorexia, except that medically necessary anorectics are covered for recipients previously diagnosed as having pickwickian syndrome and currently diagnosed as having diabetes and being morbidly obese.

(b) Agents when used to promote fertility.

(c) Agents when used for cosmetic purposes or hair growth.

(d) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(e) Drugs described in §107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of 21 CFR §310.6(b)(1) (DESI drugs)).

(3) The following categories of drugs subject to restriction under §1927(d)(2) are covered with limitations:

(a) Agents when used for the symptomatic relief of cough and colds must be listed in the Department's "Minnesota Health Care Programs Provider Manual," on a remittance advice message, or in a Department-issued provider update.

12.a. Prescribed drugs. (continued)

(b) Nonprescription drugs must be listed in the Department's "Health Care Programs Provider Manual," on a remittance advice message, or in a Department-issued provider update.

(c) Prescription vitamins and mineral products for children, pregnant and nursing women, and recipients with documented vitamin deficiencies. The limitations do not apply to fluoride treatments. Prenatal vitamins are restricted to pregnant and nursing women.

Notwithstanding the above paragraph, some vitamins and mineral products are available for the treatment or prevention of the following diseases:

(1) niacin;

(2) calcium and calcium/vitamin D; and

(3) generic preparations equivalent to Ocuvite.

12.b. Dentures.

- Purchase or replacement of dentures is limited to one time every five years for a recipient unless the dentures are misplaced, stolen or damaged due to circumstances beyond the recipient's control, or the dentures cannot be modified if a client is missing teeth necessary to fit or anchor the dentures.

- Replacement of dentures less than five years old requires prior authorization.

- The payment rate for dentures includes instruction for the use and care of the dentures and any adjustment necessary during the first six months immediately following the provision of the dentures.

12.c. Prosthetic devices.

- Prosthetic or orthotic devices means replacement, corrective or supportive devices for the purpose of artificially replacing a missing portion of the body or to prevent or correct physical deformity or real function or to support a weak or deformed part of the body.

- Prosthetic or orthotic devices are eligible for payment with the following limitation:

  - Ambulatory aid must be prescribed by a physician who is knowledgeable in orthopedic or physiatrics, or by a physician in consultation with an orthopedist, physiatrist, physical therapist, or occupational therapist, or by a podiatrist.

- The following prosthetic or orthotic devices and repairs are not eligible for payment:

  1) A device for which Medicare has denied the claim as not medically necessary;
  2) A device that is not medically necessary for the recipient;
  3) A device, other than a hearing aid, that is provided to a recipient who is an outpatient or resident of a long-term care facility and this is billed directly to medical assistance except as in item 7.c., Medical Supplies, Equipment and Appliances;
  4) Repair of a rented device;
  5) Repair of a device if the repair is covered by warranty;
  6) Routine, periodic service of a recipient's device owned by a long-term care facility;
  7) A device that has as a purpose to serve as a convenience to a person caring for the recipient;
  8) A device that is not received by the recipient;
  9) A device that serves to address social and environmental factors and that does not directly address the recipient's physical or mental health; and
  10) A device not supplied by a medical supplier.

12.d. Eyeglasses.

- Comprehensive vision examinations and intermediate vision examinations are eligible for payment.

- Medically necessary eyeglasses are specifically defined.

- Eyeglasses which have been lost, stolen, or irreparably damaged must be an identical replacement.

- Payment will be made for a new pair of eyeglasses for:

  1) a change in the recipient's head size;
  2) a change in eyeglasses mandated by medical necessity; and
  3) for allergic reaction to the eyeglass material

- The following eyeglasses or eyeglass services are not covered:

  1) eyeglasses and lenses not covered by a contract obtained through the competitive bidding process;
  2) cosmetic services. Examples are: contact lenses prescribed for reasons other than aphakia, keratoconus, aniseikonia, marked acuity improvement over correction with eyeglasses, or bandage lenses;
  3) dispensing services related to a noncovered service;
  4) replacement of lenses or frames to change the style or color;
  5) fashion tints and polarized lenses, unless medically necessary;
  6) protective coating for plastic lenses;
  7) edge and anti-reflective coating of lenses;
  8) industrial or sport eyeglasses, unless they are the recipient's only pair and are necessary for vision correction;
  9) eyeglasses, lenses, or frames that are not medically necessary;
  10) invisible bifocals or progressive bifocals;
  11) an eyeglass service for which a required prior authorization was not obtained;

12.d. Eyeglasses. (continued)

12) replacement of lenses or frames due to provider error in prescribing, frame selection, or measurement. The provider making the error is responsible for bearing the cost of correcting the error;
13) services or materials that are considered to be experimental or nonclinically proven by prevailing community standards or customary practice;
14) eyeglass repair during the warranty period if the repair is covered by warranty;
15) purchase of eyeglasses or lenses not covered by a contract obtained through the competitive bidding process;
16) backup eyeglasses;
17) photochromatic lenses, except for a recipient who has a diagnosis of albinism, achromatopsia, aniridia, blue cone monochromastism, cyctinosis, or retinitis pigmentosa, or any other condition for which such lenses are medically necessary;
18) transition lenses;
19) high index plastic lenses; and
20) eyeglasses or lenses for occupational or educational needs, unless it is the recipient's only pair and are necessary for vision correction.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

See items 13.a. through 13.d.

13.a. Diagnostic services.

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.

13.b. Screening services.

- Must be medically necessary, the least expensive, appropriate alternative, and delivered by an enrolled MA provider.

13.c. Preventive services.

- Preventive services are health services provided to a recipient to avoid or minimize the occurrence or recurrence of illness, infection, disability, or to provide care for pregnancy.

- Services must be provided to the recipient on a face-to-face basis.

- The services must affect the recipient's care rather than the recipient's environment.

- The service must not be otherwise available to the recipient without cost as part of another program funded by a government or private agency.

- The service must not be part of another covered service.

- The service must be to avoid or minimize an illness, infection, or disability which will respond to treatment.

- The service must be generally accepted by the provider's professional peer group as a safe and effective means to avoid or minimize the illness, infection, or disability.

- Prior authorized cardiac rehabilitation services are covered preventive services with the following limitations:

  1) The services must be defined services whereby a physician is on the premises of the active program at all times in which the facility is opened.

  2) The services must be conducted in an area set aside for the exclusive use of the program while it is in session.

  3) The service must be a Medicare approved cardiac rehabilitation program.

13.c. Preventive services. (continued)

- The following services may be offered within the cardiac program as a covered service:

  1) diagnostic testing - stress testing;

  2) ECG monitoring;

  3) other reasonable and necessary diagnostic services;

  4) psychotherapy,

  5) exercise therapy.

- The following cardiac rehabilitation services are not eligible for payment:

  1) services provided without the direct on premises supervision of a physician;

  2) physical therapy and occupational therapy in connection with a cardiac rehabilitation program unless there is also a diagnosis of a non-cardiac condition requiring such therapy;

  3) patient education.

- The following preventative services are not eligible for payment:

  1) service that is only for a vocational purpose or an educational purpose that is not health related; and

  2) service dealing with external, social, or environmental factors that do not directly address the recipient's physical or mental health.

14. Services for individuals age 65 or older in institutions for mental diseases.

- See items 14.a. to 14.c.

14.a. Services for individuals age 65 or older in institutions for mental diseases - inpatient hospital services.

- Same service limitations apply as those listed in item 1, Inpatient hospital services.

14.b. Services for individuals age 65 or older in institutions for mental diseases - nursing facility services.

- Same service limitations apply to those listed in item 4.a., Nursing facility services.

14.c. Services for individuals age 65 or older in institutions for mental diseases - intermediate care facility services.

- Same service limitations apply as those listed in item 4.a., Nursing facility services.
- Reserved bed services as provided as indicated in Attachment 4.19-C.

15.a. Nursing facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31) of the Act, to be in need of such care.

- Same service limitations apply as those listed in item 4.a., Nursing facility services.

15.b. Intermediate care facility services (other than services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31) of the Act, to be in need of such care including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

- The same service limitations apply as specified in item 15.a.

16. Inpatient psychiatric facilities services for individuals under 22 years of age:

- The same service limitations apply as specified in item 1, Inpatient hospital services.
- The facility must be JCAH accredited.
- Services are covered for individuals who have reached age 21, but not age 22, only if an individual was receiving such services during the period immediately preceding the individual's 21st birthday. In these cases, services may be continued up to the date an individual no longer requires services or the date the individual reaches age 22, whichever date is earlier.

MAR 0 9 2001

17. Nurse midwife services.

Payment is limited to services provided within the scope of practice of the certified nurse midwife. In addition to traditional nurse midwife services, services within the scope of practice are:

- annual physical exams;
- prescribing the full range of birth control methods;
- administering Norplant, Depo Provera;
- diagnosing and treating sexually transmitted diseases;
- preconceptual counseling;
- evaluating breast masses and making referrals for follow-up;
- evaluating abdominal pain and making referrals for follow-up;
- evaluating women for hormone replacement therapy; and
- if administering pediatric vaccines as noted in item 5.a., Physicians' services within the scope of their licensure, certified nurse midwives must enroll in the Minnesota Vaccines for Children Program.

18. Hospice care (in accordance with section 1905 (o) of the Act):

A recipient must meet each of the following conditions to receive hospice services under medical assistance:

(1) The recipient must be certified as terminally ill (i.e., the medical prognosis is that the recipient's life expectancy is six months or less, given that the terminal illness runs its normal course) within two calendar days after hospice care is initiated. A recertification statement saying the recipient is terminally ill must be obtained within two calendar days after the recipient's first 90 days of hospice care (within two calendar days after the beginning of the next 90 day period) and before each 60-day period that follows. If the hospice does not obtain written certification within two calendar days after hospice care begins, a verbal certification may be obtained within these two days and a written certification obtained no later than eight days after care begins.

(2) The recipient must live in the recipient's own home, in the community, or in a long-term care facility.

(3) The recipient must sign an election of hospice statement containing the following:

(a) the name of the hospice;
(b) an acknowledgment that the recipient understands that the hospice provides palliative, not curative care;
(c) an acknowledgment that the recipient's right to receive Medicaid payment for certain other Medicaid services (including Medicaid waivers) is being waived; and
(d) the recipient or legal representative's signature.

(4) The recipient must receive hospice care until the recipient is no longer certified as terminally ill or until the recipient or representative revokes the election of hospice.

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

The core services listed below must be provided directly by hospice employees. A hospice may use contracted staff, such as physicians, dentists, optometrists or chiropractors to supplement hospice employees during periods of peak patient loads or other extraordinary circumstances. The hospice remains responsible for the quality of services provided by contracted staff.

(1) Nursing services provided by or under the supervision of a registered nurse.

(2) Medical social services provided by a social worker under the direction of a physician.

(3) Counseling services provided to the terminally ill recipient and the family members or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or other caregiver to provide care and to help the recipient and those caring for the recipient adjust to the recipient's approaching death.

The following additional services must also be made available by the hospice:

(1) Inpatient care including procedures necessary for pain control or acute or chronic symptom management. Inpatient care is provided in a Medicare or medical assistance certified hospital, a nursing facility or an inpatient hospice unit.

(2) Inpatient care for up to five consecutive days at a time to provide respite care for the recipient's family or other persons caring for the recipient at home. Inpatient care is provided in a Medicare or medical assistance certified hospital, a nursing facility, an inpatient hospice unit, or a Medical Assistance certified intermediate care facility.

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

(3) Medical equipment and supplies, including drugs. Only drugs or compounded prescriptions approved by the commissioner for inclusion in the Department's Drug Formulary are covered. The drugs must be used primarily to relieve pain and control symptoms for the recipient's terminal illness. Medical appliances and durable medical equipment are included, as well as other self help and personal comfort items related to the palliation or management of the recipient's terminal illness. Medical appliances must be provided by the hospice for use in the recipient's home while the recipient is receiving hospice care. Medical supplies include those specified in the written plan of care.

(4) Home health aide services and homemaker services. Home health aides may provide personal care services. Home health aides and homemakers may perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient. Examples of household services are changing the recipient's bed linens, or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Home health aide services must be provided under the supervision of a registered nurse.

(5) Physical therapy, occupational therapy, and speech/language pathology services provided to maintain activities of daily living and basic functional skills.

(6) Services of a physician, dentist, optometrist, or chiropractor.

(7) Any other items or services specified in the plan of care for which payment may be made.

There are four levels of care into which each day of hospice care is classified.

(1) Routine home care day. This is a day in which the recipient is at home and is not receiving continuous care during a crisis.

18. Hospice care (in accordance with section 1905(o) of the Act: (continued.)

(2) Continuous home care day. This is a day in which the recipient receives predominately nursing services, and may also receive home health aide or homemaker services on a continuous basis during a period of crisis. The hospice must provide at least eight hours of care and bills using the hourly rate for the actual hours of service provided up to 24.

(3) Inpatient care day. This is a day in which the recipient received inpatient care for respite for the caregiver at home. The hospice may bill for up to five consecutive days beginning with the day of admission but excluding the day of discharge. Any respite care days beyond the five consecutive covered days must be billed as routine home care days.

(4) General inpatient day. This is a day in which the recipient receives general inpatient care in a hospital, nursing facility, or inpatient hospice unit for control of pain or management of acute or chronic symptoms that cannot be managed in the home. The hospice may bill for the date of admission, but not the date of discharge unless the recipient is discharged deceased.

Medical assistance will pay a hospice for each day a recipient is under the hospice's care. The limits and cap amounts are the same as used in the Medicare program except that the inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS).

No payment is made for bereavement counseling.

19. Case management services:

- Provided with limitations identified in Supplements 1 and 1A to this Attachment.

20. Extended services to pregnant women:

- See items 20.a. ~~through~~ and 20.b.

20.a. Pregnancy-Related and Post Partum Services for 60 Days After the Pregnancy Ends:

- The following are extended services for pregnant women which vary in amount, duration, and scope from other services under this State Plan.

- For the purposes of item 20.a., "physician" includes a doctor of osteopathy pursuant to 42 CFR §440.50(a).

PRENATAL RISK ASSESSMENT: All pregnant women receiving prenatal care services funded by the State of Minnesota will be screened for risk of a poor birth outcome. Factors in the assessment will include:

(1) lifestyle risk, including use of alcohol and illicit or non-prescription drugs, smoking, diet, and activity;
(2) medical risk;
(3) genetic risk;
(4) pre-term birth risk;
(5) psycho-social risk, including lack of emotional supports, stress, and lack of parenting skills.

Risk assessment activities include:

(1) To be eligible for MA reimbursement for the delivery of the enhanced perinatal services, a physician, certified nurse midwife, or nurse practitioner shall complete a risk assessment at the recipient's first prenatal visit (and, optionally, again at approximately 24-28 weeks gestation) on the form supplied by the Department of Human Services.

(2) Physicians, certified nurse midwives, and nurse practitioners must submit the completed risk assessment form to the Department of Human Services.

(3) The primary provider (physician, certified nurse midwife, or nurse practitioner) will receive a payment for each risk assessment form submitted to the Department (2 payments per pregnancy; limited to 4 payments per year; i.e. more than one pregnancy in a year).